VERMONT FUTURES
STRATEGIC IMPLEMENTATION PLAN
TRANSFORMING AND SUSTAINING A COMPREHENSIVE CONTINUUM OF MENTAL HEALTH CARE FOR ADULTS
February 2005 – June 2010

Draft July 11, 2005

(List of Abbreviations at end)

PLAN OVERVIEW

Basis and Scope This implementation plan is based on the Designated Agency Sustainability Study, the Vermont State Hospital Futures Plan: Report to Secretary Smith and Secretary Smith's Recommendations for the Future of Services Provided at Vermont State Hospital to the Legislature, the Health Resources Allocation Plan (H-RAP) and the State Health Plan. The scope of this implementation plan is quite broad; it reconfigures the existing 54-bed capacity at VSH into a new array of inpatient, rehabilitation, and residential services for adults. The proposal also calls for significant investments in the core community capacities that proactively meet people's needs thereby reducing our reliance in inpatient services. In addition, the Futures implementation plan calls for the continued transformation of our service system towards a trauma-informed, recovery oriented, and voluntary system of supports. Finally, this plan identifies the major decision points, implementation milestones, estimated resources needed, and process for stakeholder input in the design and implementation of programs.

Values and Assumptions Informing This Plan

- All people with psychiatric disabilities should have access to high quality, clinically appropriate care across a broad continuum of services.
- Widespread recognition of the negative effects of institutional settings on a person's recovery, and of the inadequacy of the hospital's antiquated physical plant.
- The scheduled loss of federal funds due to federal policy changes affecting all of the country's institutes for mental disease (IMDs), of which VSH is one.
- Widespread recognition of the benefits of integrating psychiatric inpatient care with general inpatient medical services, and of the need to end VSH's historic isolation. Therefore, the provision of psychiatric inpatient services in a stand-alone IMD is not consistent with Vermont's policy of integrating mental health and general health care services.
- The State has ultimate responsibility for the provision and/or oversight of involuntary inpatient care.
- The expertise and experience of the current VSH staff is a valuable resource.
- Vermont's hospitals and designated agencies (DAs) should play an expanded role in the future care of discrete populations.
- The State must remain committed to the principle of maintaining the locus of care in the community.

Summary Conclusions The following statements summarize a general consensus among stakeholders as of June 2005.

1. The current VSH facility should be replaced; replacement facility or facilities will be smaller than 54 beds; and should be operated with meaningful programmatic integration with medical and ongoing community mental health services.
2. The operations and human resources of the current VSH must be supported, and enhanced so that the environment is safe and the clinical programming effectively supports recovery.
3. The network of community support services and capacities should be expanded to help meet needs in a clinically appropriate manner and in keeping with system values.

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Overarching Components

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OVER ARCHING COMPONENTS

Develop Vision / Description of a Comprehensive Continuum of MH Services

Action Steps & Decision Points	Timeline	Key Players
Review proposed phasing of program implementation	2005 July	BGS, VDH, VSHFAC
Create overall system design including component parts	September	VDH, VSHFAC, VCDMH, SPSC, private providers/payors
Revise phasing based on input	September	VSHFAC, MHOC
Identify key system gaps by component and geography	November	VDH, private providers/payors
Revise plan & work group approach as needed	December, ongoing	VDH, VSHFAC, VCDMH, SPSC VDH, VSHFAC, VCDMH

TRANSFORMING THE ACUTE CARE SYSTEM

SERVICE COMPONENTS RECOMMENDED IN THE FUTURES PLAN

The Futures plan calls for the development of the new levels of inpatient care and new crisis stabilization or acute care triage resources. Specifically, two new levels of **inpatient care** called intensive care units (ICU) and specialized inpatient programs (SIP) (estimated capacity of 32 beds) are proposed both of which reflect more intensive staffing patterns than currently exist at VSH or in Designated Hospital programs. In addition, the plan proposes ***Crisis stabilization / observation beds*** (10 beds) in geographically dispersed locations to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization. The Futures plan also envisions a ***Care Management Program*** to ensure that the system can manage and coordinate access to high intensity services so that Vermonters have access to the appropriate level of care and the system's resources are used efficiently. Finally, the plan proposes to create two new programs designed to meet the needs of a longer-term care population currently served at VSH but who do not meet active treatment standards for inpatient care (***sub-acute rehabilitation service*** capacity of 16-20 and ***secure residential treatment*** capacity of 6).

Sub Acute Rehabilitation Capacity

Action Steps & Decision Points	Timeline	Key Players
	2005	
FY 06 Appropriation $763,400 G.F.	February	BGS, VDH CFO, AHS Secretary
Engage designated providers in program development	March	VCDMH, Adult MH Director
Clarify BISHCA Jurisdiction for CON	June	VDH Chief Attorney
Identify potential site locations	June	Sub-Acute Work Group
Refine programmatic characteristics	Ongoing	Sub-Acute Work Group
Solicit feedback on site locations and program characteristics	June, ongoing	SPSC & LPSCs; VSHFAC; MHOC
Request necessary zoning permits, engage local communities in program plans and solicit feedback	June-Dec	DA Leadership
FY 07 Appropriation	Aug-Dec	DA Leadership, MH Deputy
To Be Developed		
Resolve legal status of program (voluntary, involuntary) and of program residents (decision may entail additional activities, legislative changes)	October	VDH CFO, AHS Secretary Sub-Acute Work Group, VDH, Chief Attorney
Recruit and train staff	November	DA Leadership
Begin transition of VSH patients	Nov – Dec January 06	VSH & DA Clinical Teams

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Secure Residential Treatment Capacity

Action Steps and Decision Points	Timeline	Key Players
	2005	
FY 06 Appropriation $241,782 G.F.	February	BGS, VDH CFO, AHS Secretary
Engage designated providers in program development	March	VCDMH, Adult MH Director
Clarify BISHCA Jurisdiction for CON	June	VDH Chief Attorney
Identify potential site locations	June	Residential Work Group
Refine programmatic characteristics	Ongoing	Residential Work Group
Solicit feedback on site locations and program characteristics	June, Ongoing	SPSC & LPSCs; VSHFAC; MHOC
FY 07 Appropriation To Be Developed	October	VDH CFO, AHS Secretary
Resolve legal status of program (voluntary, involuntary) and of program residents (decision may entail additional activities, legislative changes)	November	Residential Work Group, VDH, Chief Attorney
Refine security and staffing plans	November	DA Leadership
Develop protocols with local law enforcement	November	DA Leadership
Recruit and train Staff	Nov-Dec	DA Leadership
Rent single family home/apartments	December	DA Leadership
	2006	
Begin transition of VSH patients	January	DA Leadership

New Inpatient Capacity

Action Steps and Decision Points Phase 1: Planning & Site Selection	Timeline 7/05-6/06	Key Players
	2005	
FY 06 Appropriation $625,000 Capital Budget	February	BGS, VDH CFO, AHS Secretary
Formalize creation of Inpt work group	July	VSHFAC
Identify pro's and con's of single vs multiple sites	August	Inpt Work Group
Develop recommendation for single or multiple sites	September	Inpt Work Group, VSHFAC, MHOC
Architectural Program Schematic Design		
FY 07 Appropriation To Be Developed	October	VDH CFO, AHS Secretary
Identify options of inpatient partner(s) and location(s)	By Dec	MH Deputy, Inpt Work Group
	2006	
Solicit feedback on partner and location options	January	VSHFAC, MHOC
Independent study to determine number of inpatient beds needed for CON process	January	MH Deputy & Contractor
Refine bed capacity needed	February	Inpt Work Group, VSHFAC, VDH MH Deputy & Inpt Partner
Identify land to purchase if stand alone construction	February	Inpt Partner, Buildings & General Services, Contractor
Submit BISHCA CON Letter of Intent	March	VDH Chief Attorney
Preliminary architectural and engineering studies	Feb-June	Inpt Partner & MH Deputy
BISHCA Asserts Written Letter of Jurisdiction	April	BISCHA Commissioner
Public process for construction (zoning, select board)	May-Oct	Inpt Partner, VDH Chief Attorney
Permitting process	Ongoing	

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Action Steps and Decision Points Phase 2: Design and CON	Timeline 7/06-12/07	Key Players
Draft Construction Drawings Request extension for CON application **Solicit feedback on draft drawings** State and Local permitting process Submit full application to BISHCA for CON (site and architectural plans schematic label; basic electrical and mechanical engineering details - sufficient for BISHCA) Submission to & review of additional information by BISHCA BISHCA Rules "Application Complete" and issues public notice for competing applications, interested party status or Amicus Curiae Public oversight commission hearing date scheduled Commissioner BISHCA makes final determination of CON	<u>2006</u> November September December, Ongoing <u>2007</u> May May June - Aug August September December	BGS, Contractor VDH Chief Attorney Inpt Workgroup, SPSC, Stakeholder Advisors, Legislature BGS, Inpt Partner, VDH Chief Attorney BGS, Inpt Partner, VDH Chief Attorney Inpt Partner, VDH Chief Attorney, BISHCA staff BISHCA Commissioner BISHCA Staff BISHCA Commissioner
Action Steps and Decision Points Phase 3: Construction & Program Design	Timeline 1/08-12/09	Key Players
Groundbreaking Construction Initial program design **Solicit feedback on program design** Revise program design		BGS, Building Contractor BGS, Building Contractor Inpt Partner, VDH, VSH Staff SPSC, Partner Advisory Groups, legislature Inpt Partner, VDH, VSH Staff
Action Steps and Decision Points Phase 4: Program Implementation	Timeline 1/10-6/10	Key Players
Staff Recruitment and Training Clinical and Program Characteristics Refined		Inpt Partner, VSH staff Inpt Partner, VSH staff
Crisis Stabilization Beds		
Action Steps and Decision Points	Timeline	Key Players
FY 07 Appropriation To Be Developed Clarify Role of these Beds w/ Emergency Directors & local stakeholders including Public Inebriate use ? Complete geographic analysis for proposed locations **Solicit Feedback on program roles & on proposed locations** Solicit program development options in target areas Refine programmatic characteristics **Solicit feedback on program characteristics** Revise program plans Recruit and train staff Program start up	<u>2005</u> October October November November December <u>2006</u> February March April August September	BGS, VDH CFO, AHS Secretary VCDMH, VDH, CM Work Group VDH, VCDMH VSHFAC, SPSC, MHOC VDH DA Leadership VSHFAC, SPSC, LPSCs, MHOC DA Leadership DA Leadership DA Program Staff

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Care Management System		
Action Steps and Decision Points	Timeline	Key Players
	2005	
Formalize Identification of CM Work Group	July	VSHFAC
FY 07 Appropriation To Be Developed		
Develop program design, screening, triage, disposition protocols in collaboration with stakeholders	October	VDH CFO, AHS Secretary
	December	CM Work Group
Solicit feedback on program design	2006	
Refine program design	January	VSHFAC, SPSC, LPSCs, MHOC
Define IT System support needs	March	CM Work Group
Design management approach and staffing plan	April	CM Work Group
Pilot protocols	May	CM Work Group
Revise protocols based on pilot	June	Participating partners
Design IT system	July	CM Work Group
Implement	August	Contractor (likely)
	October	Participating partners

SUSTAINING & BUILDING THE OPERATIONS AT VSH		
The current program at Vermont State Hospital		
Operations at the current VSH will continue until the new program capacities described in the Futures plan can be implemented. As community capacities come on line, the bed capacity at the VSH can begin to shrink. However, due to the need to enhance the current VSH staffing levels, significant staff reductions are not anticipated. The investments made now in the staff and resources at the current VSH will assist in building towards an excellent, state-of-the-art psychiatric inpatient service in the future.		
Action Steps and Decision Points	Timeline	Key Players
	2005	
Develop enhanced staffing plan	February	VSH leadership
FY 06 Appropriation $16,274,074 G.F.	March	VDH CFO, AHS Secretary
Design staff recruitment & retention package	April	VSH Leadership, AHS Deputy
Implement staffing pattern	Ongoing	VSH leadership
Develop Fletcher Allen contract for psychiatry svcs	May	VDH leadership
Approve Fletcher Allen Contract	June	VDH Commissioner, Administration, VSH Governing Body
Continue facility improvements	Ongoing	VSH leadership, Buildings and General Svcs
Continue improvements to Clinical and Quality Systems	Ongoing	FAHC, VSH Leadership, VSH Governing Body MHOC
FY 07 Appropriations Request To Be Developed	October	VDH CFO, AHS Secretary

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ENHANCING COMMUNITY INFRASTRUCTURE

SERVICE COMPONENTS RECOMMENDED IN THE FUTURES PLAN

The Futures Plan calls for the transformation of community based and peer services into a voluntary and upstream system of supports and services that ultimately reduces Vermont's reliance on psychiatric inpatient care and involuntary care. These services need to respond to the practical needs of citizens and be appropriately geographically dispersed. In addition, this continuum of supports and services will be recovery-oriented and trauma informed. Specifically, the Futures Plan calls for the development of the following new services.

Supportive Housing safe and adequate housing is crucial to reducing hospitalization and supporting recovery.
Peer Programming offers effective, recovery-oriented supports. The plan proposes to create new peer support programs targeted to individuals who use VSH. In addition to new peer programming, peers can and should be an integral part of the provision of traditional services. This area, both stand alone peer services, and the integration of peers into formal services needs more exploration. This plan includes funding for ***Transportation*** costs, made necessary by the geographical distribution of programs. If the inpatient hospital beds are distributed in more than one location, this plan includes additional resources for ***Legal services***, due to the higher costs of having attorneys consult with clients and witnesses in multiple locations.

Additional Recommendations by Secretary Charles Smith to the Legislature

Secretary Charles Smith's February 4th recommendations to the Legislature included additional program capacities not named in the Futures Plan. These include the implementation of the Mental Health Plan for Corrections and other community-based mental health services designed to strengthen the outpatient and co-occurring treatment infrastructure. Specifically these are:

Adult Outpatient Services added capacity for the community mental health agencies and / or private providers to provide adult out-patient service. Examples might include:

- A program focused specifically on the mental health needs of service men and women returning from a war zone, and / or their families during the deployment;
- Replication of the HCRS (Health Care & Rehabilitation Services of Southeastern Vermont) program for cost-effective management of pre-CRT (Community Rehabilitation and Treatment) individuals;
- Collaboration with the Department of Children and Families to intervene with specific TANF (Temporary Assistance for Needy Families) families on issues of depression and substance abuse.
- Integration of mental health care into primary care settings such as federally qualified health centers.

Offender Out-Patient calls for capacity for the community mental health agencies and / or private providers to serve the mental health and substance abuse needs of selected offenders who are returning to the community following incarceration with priority given to interventions with a high potential of supporting the offender's long-term success.
Expansion of the Co-Occurring Disorders Project This is a successful collaboration between the Department of Corrections and the Department of Health divisions of Mental Health and of Alcohol and Drug Abuse Programs. Using integrated mental health and substance abuse treatment, teams in Burlington and Brattleboro provide outpatient treatment to severely ill and addicted offenders. These teams combine Corrections' field staff, mental health clinicians, and substance abuse clinicians. Clients are seen daily in the community or in group treatment. Results show a markedly reduced risk of re-offense, reduction in hospital care, and good recovery results. Two new teams are proposed, in Rutland and Barre.
Public health prevention and education strategies with the reorganization of the Agency of Human Services, the divisions of Mental Health, of Alcohol and Drug Abuse Programs, and of Community Public Health are now together within the Department of Health. This creates a special opportunity to apply public health, population based prevention and early intervention techniques to the field of mental disease and substance abuse. New resources will be used to craft and communicate the public health, early intervention message with respect to mental illness. We will continue and expand on work presently being done with primary care physicians and their staffs on diagnosing and treating depression, and on making referrals to appropriate specialized services. This work will benefit from coordination with Vermont's chronic care initiative, the Blueprint for Health.

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Peer Services		
Action Steps and Decision Points	Timeline	Key Players
	2005	
FY 07 Appropriations Request To Be Developed	October	VDH CFO, AHS Secretary
Develop program approach	December	VPS, SPSC
	2006	
Solicit input on program approach	January	VSHFAC, LPSCs, MHOC
Identify location based on geographic need	February	VPS
Solicit proposals from peer organizations	May	SPSC (consider)
Review proposals	June	SPSC or Ad Hoc Review Committee
Develop contract	July	VDH
Program start up	August	Contractor

Supported Housing		
Action Steps and Decision Points	Timeline	Key Players
	2005	
FY 07 Appropriations Request To Be Developed	October	VDH CFO, AHS Secretary
Develop program approach	December	VCDMH, VPS, SPSC
	2006	
Solicit input on program approach	January	VSHFAC, LPSCs, MHOC
Identify location based on geographic need	February	VCDMH, SPSC
Determine viability of HUD or other funding options	March	VDH
Identify sites, renovation / acquisition costs	May	VDH
Identify Providers (depends on program approach)	May	VDH
Next steps based on decisions above		

Adult Outpatient Service		
Action Steps and Decision Points	Timeline	Key Players
	2005	
FY 07 Appropriations Request To Be Developed	October	VDH CFO, AHS Secretary
	2006	
Identify priority population	January	VCDMSP, AHS Field Directors
Develop program approach	March	VCDMSP, AHS Field Directors
Match programs to geographic region	April	VCDMSP, AHS Field Directors
Solicit input on program approach and geographic region	May	VSHFAC, SPSC, LPSC, MHOC
Identify service providers (RFP or DA Network)	June	VDH
Program start up (depends on decisions above)	July	Contractor

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Offender Outpatient Service		
Action Steps and Decision Points	Timeline	Key Players
	2005	
FY 07 Appropriations Request To Be Developed	October	VDH CFO, AHS Secretary
	2006	
Identify priority population	January	VCDMSP, AHS Field Directors, DOC
Develop program approach	March	VCDMSP, AHS Field Directors, DOC
Match programs to geographic region	April	VCDMSP, AHS Field Directors, DOC
Solicit input on program approach and geographic region	May	VSHFAC, SPSC, LPSC, MHOC
Identify service providers (RFP or DA Network)	June	VDH
Program start up (depends on decisions above)	July	Contractor

Expansion of Co-Occurring Disorders Project		
Action Steps and Decision Points	Timeline	Key Players
	2005	
FY 07 Appropriations Request To Be Developed	October	VDH CFO, AHS Secretary
Solicit Input on proposed geographic areas	November	VSHFAC, ADAP, DOC, AHS Field Directors
	2006	
Identify target population	January	ADAP, DOC, VDH, AHS Field Directors
Refine program model	February	ADAP, DOC, VDH
Solicit feedback on program approach and target population	March	VSHFAC, SPSC, MHOC
Finalize program model	April	ADAP, DOC, VDH
Identify service providers (RFP or DA Network)	June	ADAP, DOC, VDH
Program start up (depends on decisions above)	July	Contractor

Transportation (Voluntary and Involuntary)		
Action Steps and Decision Points	Timeline	Key Players
	2005	
FY 07 Appropriations Request To Be Developed	October	VDH CFO, AHS Secretary
Develop safety guidelines	November	Sheriffs, MH Emergency Directors, NAMI, VPS
	2006	
Train on approach, pilot	January	VDH, Sheriffs, Emergency Directors
Evaluate efficacy, revise as needed	March	VDH, Sheriffs, Emergency Directors
Start training program for local law enforcement	May	VT Police Academy
Revise AHS contract with Sheriffs	May	AHS
Write regulation to authorize ambulance transport	June	VDH

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Ancillary Legal Services		
Action Steps and Decision Points	Timeline	Key Players
Identify potential changes **Work group recommended?** **Statutory changes required?** (next steps dependent on above) Quantify impact of potential changes to legal system	2005 October November November	VDH Chief Attorney, Legal Aid, VT P&A VDH Chief Attorney, Legal Aid, VSHFAC VDH Chief Attorney, Legal Aid, VSHFAC
Public Health Prevention Initiatives		
Action Steps and Decision Points	Timeline	Key Players
Work with stakeholders to identify prevention priorities consistent with the New Freedom Commission	June 06	VDH, SPSC,LPSC, NAMI-VT, VPS

SUSTAINING COMMUNITY INFRASTRUCTURE		
The Designated Agency Sustainability Study, conducted in the Fall of 2004, made several recommendations regarding the effectiveness and sustainability of the Designated Agency network for the provision of community mental health, developmental, and alcohol and drug treatment services. Based on this report, AHS Secretary Charles Smith recommended that a multi-year budget planning cycle be developed. Below are the specific action steps he recommended.		
Action Steps and Decision Points	Timeline	Key Players
Develop Allocation Agreement Between Cost of Living Adjustment and Service Growth Requirements Identify Medicaid Maximization Opportunities / Risks Target Resources to Adult Outpatient, Emergency, and Substance Abuse Programs Establish FY 06 Allocations and Performance Contracts Start DA Designation Cycle Assist in Design of Cost Containment for Medicaid Pharmacy Plan	2005 February March Ongoing July July June- Dec	VDH, DAIL, VCDMH VDH, DAIL, VCDMH DA Providers VDH, DAIL, VCDMH VDH, DAIL VDH, VCDMH, OVHA
Solicit input to proposed pharmacy plan approach	2006 January 06	OVHA, SPSC, (others)
Begin System Improvement Process to: - Develop comparable financial and performance data across DA providers - identify redundancy in data collection procedures - Focus data collection on most impactful measures of system performance and client outcomes - Establish, with stakeholders, clear performance expectations - Design consistent "therapeutic thresholds" and individual case plans - Vermonters with comparable needs will receive comparable services regardless of DA provider - Develop case mix factors for DA budget allocation - Apply case mix concepts to annual performance contracts	TBD	VDH, DAIL, VCDMH, SPSC, LPSCs

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LIST OF ABBREVIATIONS

ADAP Division of Alcohol and Drug Abuse Programs
BGS Buildings and General Services
BISHCA Banking, Insurance, Securities and Health Care Administration
CM Work Group Care Management Work Group
CON Certificate of Need
DA Designated Agency to provide comprehensive mental health services in a defined geographic region
DAIL Department of Disabilities, Aging and Independent Living
DOC Department of Corrections
H-RAP Health Resource Allocation Plan
ICU Intensive care unit (inpatient)
IMD Institute for Mental Disease (stand alone psychiatric hospital or program)
Inpt Inpatient
LPSC Adult Mental Health Local Standing Committee
MHOC Joint Legislative Mental Health Oversight Committee
NAMI-VT National Alliance for the Mentally Ill – Vermont chapter
OVHA Office of Vermont Health Access
SIP Specialized inpatient program
SPSC Adult Mental Health State Standing Committee
VCDMH VT Council of Developmental and Mental Health Services Providers
VDH Vermont Department of Health
VPS Vermont Psychiatric Survivors
VSH Vermont State Hospital
VSHFAC VSH Futures Advisory Committee

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